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ROC Closes Operations on August 31, 2003

This edition of the Texas Monitor is the final one published by the Research and Oversight Council on Workers' Compensation (ROC). Funding for the ROC was discontinued in late June of this year. As a result, as of August 31, 2003, the ROC will no longer exist as a stand-alone Texas state agency.

However, it is anticipated that the governor will issue an executive order transferring the research functions of the ROC to the Texas Department of Insurance (TDI). It is expected that the transferred function will retain the requirement that a periodic report on workers' compensation research and issues be provided to policymakers and the public at large. In the meantime, ROC staff appreciates the interest of Monitor readers over the years and look forward to continuing to provide timely and objective information on workers' compensation issues in a new setting.

Post-Injury Health Status of Texas Workers with Soft-Tissue Injuries

by Joseph Shields, Dana Baroni, and Xiaohua Lu

As part of its work on the development of regional workers' compensation (WC) health care network report cards to assist in the evaluation of a legislatively-mandated health care network feasibility study, the Research and Oversight Council on Workers' Compensation (ROC) conducted a survey of injured workers regarding their health status.

This article provides useful baseline data regarding various patient satisfaction, health status (emotional and physical), return-to-work, and earnings outcomes that can be compared to other populations of injured workers who may, at some point in the future, be receiving care through regional health care networks or through traditional fee-for-service health care delivery systems in Texas. Where meaningful differences are observed, they will be reported for injured workers employed by the State of Texas and private sector employers, and for injured workers who selected their own doctor or had their employer influence the selection of the their treating doctor.

Contents

Research Methodology

A stratified, random sample of injured workers employed by the State of Texas, and private sector employees was administered by the University of North Texas' Survey Research Center. Interviews with employees injured in 2000 were conducted in the fall of 2002, some 21 to 33 months after the on-the-job injury or illness occurred. The sample of injured workers was restricted to those with soft tissue injuries affecting their back, neck or shoulder areas.[1] Research findings are based on telephone interviews with 970 injured workers (156 state employees and 814 private sector employees).[2]

Key Findings

Research findings are reported for three critical areas: 1) satisfaction with the quality of medical care received by injured workers; 2) post-injury health status of injured workers; and 3) post-injury return-to-work and wage earnings experience of injured workers.

Quality of Medical Care

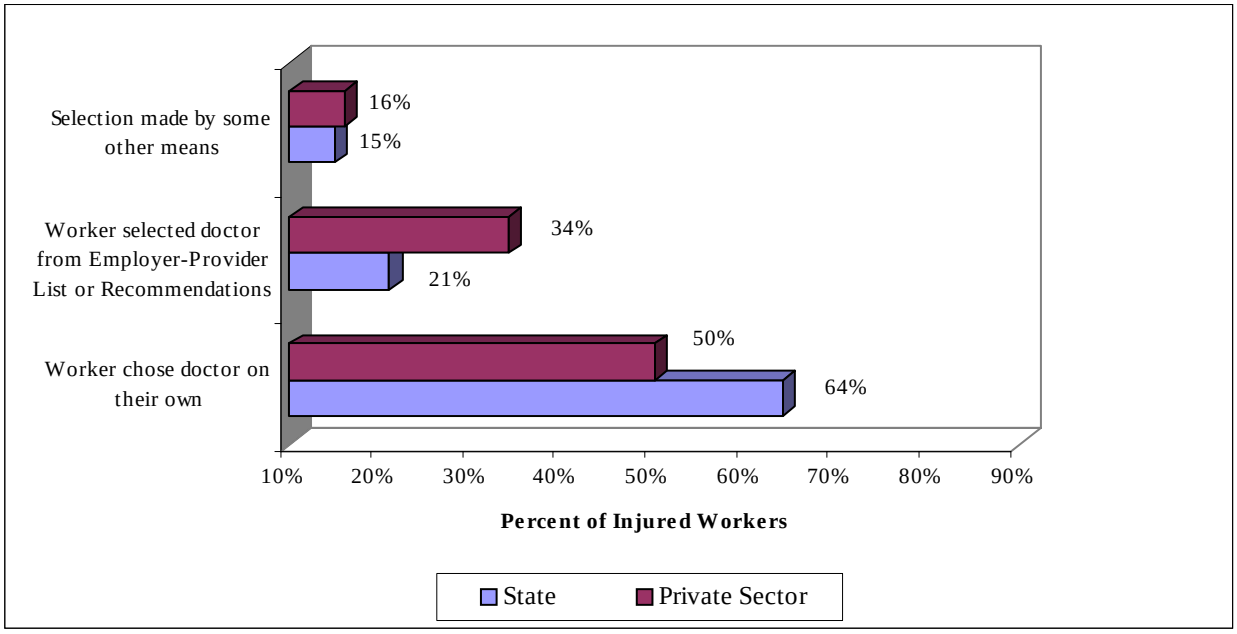
Overall, 61 percent of the injured workers interviewed indicated that they received *emergency medical care* for their on-the-job injury, and the majority (57 percent) said that they were satisfied with the quality of the emergency medical care they received. Injured state employees (71 percent) were much more likely to be satisfied with the quality of the emergency care they received for their on-the-job injury than employees injured at private-sector companies (57 percent).

Though by law Texas employees have the first choice of treating doctor, a significant proportion of injured workers surveyed (33 percent) indicated that they selected a doctor from an employer-provided list or went to a doctor recommended by their employer. As Figure 1 illustrates, a higher proportion of private-sector employees (34 percent) had their *non-emergency medical care* directed by their employer than state employees (21 percent).

An equal percentage (45 percent) of state and private-sector employees changed treating doctors (i.e., primary care doctors) at some time during the treatment of their occupational injury.

The vast majority (84 percent) of injured workers were in agreement with the statement that they were provided with very good medical care *(by the doctor they saw most often)* that met their needs—including 43 percent who

Figure 1
Selection of First Non-Emergency Doctor



Source: Research and Oversight Council on Workers' Compensation, Survey of Worker Experience with Work-Related Health Problems, 2002.

"strongly agreed" that this was the case. Most workers felt that the doctor they saw most often took their condition seriously (89 percent), gave them a thorough exam (84 percent), tried to understand their daily tasks and duties (85 percent), and had their complete trust (81 percent). These strong, positive sentiments regarding medical treatment were voiced by injured workers employed by both state agencies and private-sector firms.

While some differences were observed in the patient satisfaction levels between injured workers who chose their own treating doctor and those whose choice of doctor was influenced by their employer, it is important to note that the large majority of both injured worker groups tended to be satisfied with the quality of the medical care received for the treatment of their on-the-job injury.

Not surprisingly, injured workers who chose their own treating doctor were somewhat more likely than workers whose choice of doctor was influenced by their employer to feel: that their doctor took their medical condition seriously (92 percent vs. 83 percent); that the doctor gave them a thorough medical exam (87 percent vs. 74 percent); and that the doctor had their complete trust (84 percent vs. 74 percent). Injured workers who selected their own treating doctor were also more likely to say they would recommend their doctor to a relative or friend for a similar problem (82 percent vs. 71 percent), and a smaller percentage of those workers who chose their own doctors felt that the doctor seemed to care more about what the insurance company or employer thought about their medical care (18 percent) than those workers whose choice of doctor was influenced by their employer (31 percent). See Table 1.

Nearly three quarters (74 percent) of the survey respondents were satisfied with the medical care they received from the doctor they saw most often—including 50 percent who indicated that they were "extremely satisfied." While these proportions were roughly the same for state and private sector workers, workers who selected their own doctor (77 percent) were significantly more likely to be satisfied with the quality of care than were injured employees who chose a doctor with their employer's input (64 percent).

Post-Injury Health Status

When asked about their post-injury health status (21 to 33 months after the injury), employees reported a wide spectrum of condition levels (see Figure 2). While just 7 percent of the survey respondents said their current health was "excellent", 18 percent said it was "very good", and 33 percent reported their health status as "good." One quarter of the survey respondents said their health condition was "fair", and the remaining 17 percent reported their condition as "poor."[3]

While no significant differences in *overall health status* were observed between state and pri-

Table1
Percentage of Injured Workers in Agreement With Various Statements About the Doctor They Saw Most Often By Method of Doctor Selection

The Doctor I saw Most Often for My Work-Related Injury or Illness...	Doctor Selected from Employer Provided List or Recommended by Employer	Doctor Selected by Injured Worker
Overall, provided me with very good medical care that met my needs.	77%	85%
Is generally the type of doctor I would recommend to a relative or friend for this type of problem.	71%	82%
Gave me a thorough medical examination.	74%	87%
Took my medical condition seriously.	83%	92%
Explained my medical condition in a way that I could understand it.	83%	92%
Seemed willing to answer any medical questions I may have had.	88%	91%
Has my complete trust.	74%	84%
Treated me with respect.	90%	93%
Tried to understand my daily job tasks and duties.	82%	89%
Doubted that I was really sick or injured.	25%	19%
Seemed to care more about what the insurance company or employer thought about my care.	31%	18%

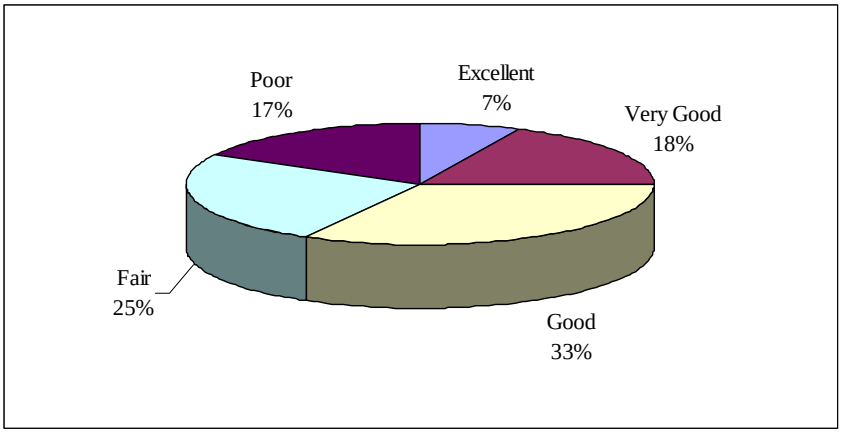
Source: Research and Oversight Council on Workers' Compensation, Survey of Worker Experience with Work-Related Health Problems, 2002.

vate sector employees, state employees were much more prone than private-sector employees to report physical limitations (particularly to more strenuous activities)[4] at the time of the interview. These differences are clearly reflected in Table 2.

A substantial percentage of injured workers indicated that, as a result of their physical health they accomplished less than they would have liked (57 percent), or were limited in the type of work or activities they were able to perform (63 percent). Emotional problems also tended to limit the activities of survey respondents after a significant amount of time had passed since their on-the-job injury took place: 45 percent of the injured workers said that, due to emotional problems, they accomplished less than they would have liked and 40 percent said they didn't do activities as carefully as usual due to emotional problems.

Over one-third of injured workers indicated that, despite the significant amount of time that had elapsed since their injury, pain still interfered with their work either "quite a bit" (22 percent) or "extremely" (15 percent).[5] Approximately two years after their on-the-job injuries took place, the population of Texas workers with work-related soft tissue back, neck, and shoulder injuries had significantly lower mean physical health (39.1) and mental health (45.9) scores (on the SF-12 Health Survey questions) than the 1998 general U.S. population (mean

Figure 2
Current Health Status: 21 to 33 Months Post-Injury



Source: Research and Oversight Council on Workers' Compensation, Survey of Worker Experience with Work-Related Health Problems, 2002.

Table 2
Degree to which Current Health Condition Limits Selected Activities: State vs. Private Sector Employees

Physical Activity	Employee Type	Limited a Lot	Limited a Little	Not Limited at All
Vigorous Activities (e.g., running, lifting heavy objects, strenuous sports)	State	59%	27%	13%
	Private Sector	47%	32%	21%
Moderate Activities (e.g., moving a table, pushing a vacuum cleaner)	State	35%	37%	28%
	Private Sector	31%	34%	35%
Lifting or carrying groceries	State	39%	35%	26%
	Private Sector	24%	37%	39%
Climbing several flights of stairs	State	44%	27%	29%
	Private Sector	33%	26%	41%
Climbing one flight of stairs	State	18%	38%	44%
	Private Sector	17%	29%	54%
Bending, kneeling, or stooping	State	42%	33%	26%
	Private Sector	33%	32%	35%
Walking more than a mile	State	41%	26%	34%
	Private Sector	31%	24%	45%
Walking several blocks	State	27%	33%	40%
	Private Sector	25%	27%	48%
Walking one block	State	16%	30%	54%
	Private Sector	13%	28%	59%
Bathing or dressing yourself	State	15%	32%	53%
	Private Sector	12%	29%	60%

Source: Research and Oversight Council on Workers' Compensation, Survey of Worker Experience with Work-Related Health Problems, 2002.

score of 50 for the physical and metal health measures).[6]

Post-Injury Return-to-Work Outcomes

As was the case with the health status findings, it is important to keep in mind that all findings related to the injured employees' employment status reflect their self-reported work and earnings activity 21 to 33 months after the occupational injury occurred, depending on the exact date of injury in 2000. Approximately one-third (34 percent) of the workers injured in 2000 reported that they were not working at the time of the interview. Seventy-one percent of state workers said they were employed at the time of the interview compared to 66 percent of workers who were employed by private sector firms at the time of their injury.

Overall, 66 percent of the workers injured in 2000 were employed at the time of the interview (Fall 2002), while 19 percent were unemployed but did return to work at some point after the injury. The remaining 15 percent had still not returned to work 21 to 33 months after their work-related injury took place. (See Figure 3.)

After controlling for whether the worker's unemployment status was related to their on-the-job injury, approximately the same percentage of state (26 percent) and private sector workers (25 percent) said that they were out of work due to their injury.

Of the nearly two-thirds of the workers who said they were employed at the time of the interview, the majority 65 percent said they were working for the same employer they worked for at the time of their injury (i.e., their injury-site employer). State workers (84 percent) were much more likely than private sector employees (65 percent) to be working for their injury-site employer.

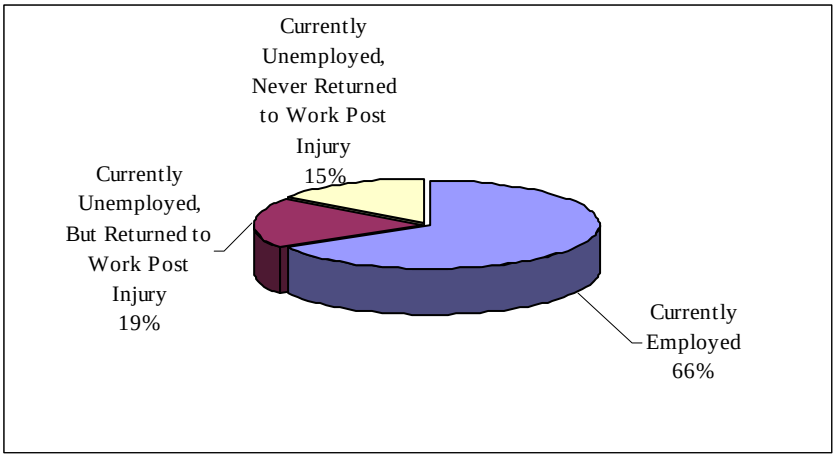
Of the workers unemployed at the time of the survey, the majority (69 percent) indicated that they lost *at least one year* of work following their injury.[7] It is important to note that this represents the total amount of time off work and may include periods of non-work that are not due to the injury.

Due to the relative stability of state employment, state workers (73 percent) were also more likely than private sector workers (65 percent) to be doing the same type of work they were doing before the on-the-job injury occurred. Of the workers employed at the time of the interview, a much higher proportion of private sector workers (34 percent) than state workers (17 percent) reported that they were earning less money at the time of the interview than they did before the injury.

Of those injured workers employed at the time of the survey, significantly more state workers (37 percent) reported losing *less than one month of time* from work (due to the injury) than workers employed by private sector firms at the time of the injury (28 percent). While state workers tended to lose less time from work due to the injury, they were also more likely than private sector workers to indicate that they went back to work "too soon" following their occupational injury (37 percent vs. 29 percent).

The vast majority of the survey respondents (89 percent) characterized their employer as a "good employer before the work-related injury took place." This

Figure 3
Return-to-Work Status: 21 to 33 Months Post-Injury



Source: Research and Oversight Council on Workers' Compensation, Survey of Worker Experience with Work-Related Health Problems, 2002.

held for both state and non-state workers. While the majority of survey respondents (59 percent) said their employer treated them with respect following their on-the-job injury, state workers (68 percent) were more likely than private sector workers (59 percent) to feel this way.

Injured workers surveyed reported that very few employers asked them not to file a claim (8 percent); however, a higher proportion of survey respondents indicated that their employer questioned whether or not an injured worker's injury was work related (22 percent).

After an injury occurred, it was much more likely that return-to-work related discussions would take place between the employer and injured worker if the worker were employed by the State of Texas, as opposed to a private sector firm. For example, 59 percent of injured state workers (versus 42 percent of private sector workers) said that their employer provided them with a written copy of the their return-to-work plan, and 70 percent of state workers (versus 61 percent of private sector workers) indicated that their employer worked with their treating doctor regarding treatment and return-to-work options.[8]

Longer pre-injury employment tenure was found to be associated with better perceived (by employee) post-injury treatment by the employer. For example, almost three-quarters (71 percent) of workers who were on the job for more than 5 years before the injury felt their employer treated them with respect after the injury, compared to just 47 percent of the workers with job tenures of less than one year prior to the occurrence of the on-the-job injury. Injured workers employed by their injury-site employer for more than 5 years prior to the injury were also significantly more likely to indicate that their employer worked with their doctor regarding treatment and return-to-work plans, that their employer tried to understand what tasks they were capable of performing when they returned to work, and that their employer provided them with a written copy of the company/agency return-to-work plan.

Conclusion

This study provides important information regarding various patient satisfaction measures, post-injury return-to-work and earnings outcomes, and the physical and emotional health of state and private sector employees in Texas who suffered work-related soft tissue injuries. The injured worker interviews reveal that there are meaningful differences between state and private sector workers when issues related to the selection of doctors, the post-injury health status of injured workers, and the likelihood of successful post-injury return-to-work and earnings outcomes.

A key, if not unexpected, finding that emerges from this analysis is that allowing an injured worker to choose his or her own treating doctor seems to impact the perception of the quality of medical care received in a positive way. Injured workers who chose their own doctors were significantly more satisfied with the medical care they received than workers who were directed to a provider either through an employer-provided list or through an employer recommendation. While it is not clear from this survey how return-to-work and physical outcomes for injured workers varied based on doctor choice, the satisfaction findings have important implications for the possible implementation of regional health care networks to treat work-related injuries. It is, however, important to note that regardless of how the treating doctor was selected (e.g., by the injured worker, from an employer-provided list of medical providers), workers tended to be fairly satisfied with the perceived quality of the medical care they received.

Notes to pages 1-6

[1] These soft tissue injuries were selected to control for injury type differences between the state and private sector samples, and because they represent a significant proportion of the workers' compensation claims in Texas. The sample was randomly drawn from the TWCC Medical Forms Database and included all soft tissue back, neck, and shoulder claims, regardless of whether the injured worker lost time from work due to the injury. The survey found that the vast majority of the survey respondents (81 percent) did lose some time from work due to the injury. This finding may indicate that more severely injured workers responded to the survey.

[2] The telephone survey was designed by the Research and Oversight Council on Workers' Compensation and MED-FX, LLC, and include a subset of questions

from the standardized SF-12 Health Survey.

[3] Percentages do not total to 100 percent due to rounding.

[4] Strenuous activities include: 1) vigorous activities-running, lifting heavy objects, strenuous sports; 2) lifting or carrying groceries; 3) climbing several flights of stairs; 4) bending, kneeling, or stooping; and 5) walking more than one mile.

[5] These percentages refer to all injured workers surveyed, not just those who indicated that they were employed at the time of the interview.

[6] The population of workers with work-related soft tissue injuries in 2000 had slightly higher physical health scores (39.2 vs. 37.6) than the population of Texas workers injured in 1997 and 1998 who were surveyed for the ROC's 2001 study (See *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*). The population of workers with work-related soft tissue injuries in 2000, also had slightly higher mean mental health scores (45.9 vs. 44.4) than Texas workers injured in 1997 and 1998 who were surveyed for the ROC's 2001 study.

[7] This total duration of lost time includes cases involving intermittent periods of lost time, as well as one continuous period of lost time following the workplace injury.

[8] These differences may be due to the fact that Texas state agencies are strongly encouraged by the risk-reward program (as well as other statutory requirements) to adopt a written return-to-work plan for injured workers, as an effective loss control strategy. Further, state agencies are required to report to Legislature (along with its biennial budget request) data related to the number of injuries, the dollar value of indemnity and medical payments made to injured workers, the injury rate per 100 employees, and a description of efforts made by the agency to reduce injuries and WC losses. See Texas *Labor Code* Section 501.048.

Survey Results Indicate Low Early Utilization of Multiple Employment Provision of HB 2600

by Jon Schnautz

Among the many statutory changes made by House Bill 2600 (77th Legislature, 2001) were modifications to the benefits available to replace the lost wages of Texas employees injured on the job. Under Texas law, employees of employers who provide workers' compensation insurance are entitled both to medical benefits and income benefits for lost wages and permanent impairment as a result of an on-the-job injury. The weekly amount of income benefits an injured employee may receive is based on the employee's pre-injury Average Weekly Wage (AWW); statutory caps also limit the amount of weekly income benefits for which an employee is eligible.[1]

Historically, since the major reform of the Texas workers' compensation system in 1989, income benefits for injured employees have been calculated based solely on wages earned at the job where they are injured.[2] Under this structure, employees who relied on wages from more than one job, and who are unable to work at any of these jobs because of a work-related injury, may receive significantly less compensation than they were earning before being injured.

In recent years some policymakers showed interest in how this system feature might adversely impact injured employees with more than one job. This interest culminated in a statutory change made by Article 10 of HB 2600 in 2001, which allows employees injured on the job on or after July 1, 2002 to claim wages from all employment reportable for tax purposes to the Internal Revenue Service (IRS) toward the calculation of their Average Weekly Wage (AWW).[3]

Because this statutory change was intended to increase income benefits for injured employees with more than one job, it was expected to increase overall workers' compensation system costs borne by employers and insurance carriers. In an effort to mitigate these costs, HB 2600 also allowed insurance car-

riers that pay additional income benefits based on multiple employment to be reimbursed for the cost of these benefits. To this end, insurance carriers are allowed to claim reimbursement for such benefits from the Texas Workers' Compensation Commission's (TWCC's) Subsequent Injury Fund (SIF).

The SIF is an account in the state's general revenue fund.[4] Its main obligation, and the reason for its creation, was to pay Lifetime Income Benefits (LIBs) in certain workers' compensation claims in which an injured employee qualifies for those benefits as a result of two injuries – for example, an employee who was blind in one eye, and then lost sight in the other as a result of an on-the-job injury.[5] Funding for the SIF is provided through payments by insurance carriers in on-the-job death claims in which no beneficiary survives the deceased employee, as well as interest earned on the SIF's balance.[6]

Since its creation, the fund has taken on other obligations, as well. The SIF reimburses insurance carriers who pay income or medical benefits based on certain orders or decisions of the TWCC administrative dispute resolution process that are later overturned. In addition, HB 2600 added three new obligations to the SIF:

1. As noted previously, reimbursement of insurance carriers for additional income benefits paid on claims involving multiple employment;
2. Reimbursement of insurance carriers for pharmaceutical benefits provided during the first seven days after an injury for claims later determined not to be compensable (i.e., not in the course and scope of employment); and
3. Payment of up to $1.5 million to fund feasibility studies related to regional workers' compensation health care networks created under Article 2 of HB 2600.

The SIF's available assets at the end of fiscal year 2002 were about $22.6 million (on a cash value basis); this amount does not include an additional $9.5 million in the fund reserved to pay LIBs to the approximately 36 injured employees who receive these benefits. Despite these significant assets, it was anticipated when HB 2600 won passage that, over the next few fiscal years, additional funding beyond the available revenue in the SIF may be needed to reimburse (in full) insurance carriers for income benefits paid based on multiple employment. To address this prospect, language was also included in Article 10 of HB 2600 allowing TWCC to make partial reimbursements to carriers in the event of a SIF shortfall, and to "shore up" the SIF with additional funding from the workers' compensation insurance carrier maintenance tax used to fund TWCC. These provisions were only to be utilized if the SIF was not projected to have adequate reserves to pay, in full, 120 percent of its projected obligations for the upcoming two-year state budget cycle.[7]

Given the important funding issues involved with the SIF, HB 2600 also required TWCC to conduct twice yearly actuarial analyses on the status of the SIF, and to report the findings of these studies to the Research and Oversight Council on Workers' Compensation (ROC), and make them available to legislators and the public, as well.

Prior Projections of Multiple Employment Impact

Because of significant concern from policymakers and system stakeholders over the implications of the multiple employment provision and the future of the SIF, several attempts have been made to assess these issues via projections and forecasts. The first and most basic effort occurred while HB 2600 was under consideration by the Legislature in 2001. The methodology used to project the cost of the multiple employment provision and its impact on the SIF was rudimentary given the short timeframe to produce an estimate, but the conclusion was that the new benefits available due to multiple employment consideration would be significant ($11-$13 million a year) and could be sustained by the SIF in the short- to medium-term, but not on an ongoing, long-term basis.

In August 2002, the ROC released a report containing updated projections of the frequency and cost of multiple employment claims for fiscal years 2002 through 2007.[8] These projections also evaluated the short-

and long-term ability of the SIF to provide reimbursement to insurance carriers. The methodology was similar to the original cost estimates but much more thorough and detailed.

Based on the projected frequencies and amounts of additional income benefits that would be paid to injured employees under the multiple employment provision, and with consideration of a four-year "learning curve" to account for the likelihood that not all injured employees eligible for additional benefits will claim these benefits, it appeared that the SIF would be sufficient to reimburse carriers fully through FY 2006 or 2007, without any increase in the carrier maintenance tax or need to make only partial reimbursements.

Another effort to estimate the effect of the multiple employment provision on the SIF occurred in February 2003, when, in accordance with the statutory mandate from HB 2600, TWCC released its most recent actuarial analysis of the SIF.[9] While the methodology used in this report differed from the ROC's analysis on some points, the same conclusion (that the SIF would provide sufficient short- to medium-term funding for full reimbursements to insurance carriers) could be drawn based on the findings, again assuming a four-year "learning curve" to maximum utilization of the provision by injured employees.

While the latter two projections were based on consideration of all factors relevant to the SIF's income and expenses, and while they were much more detailed than the original estimates produced at the time HB 2600 was being considered by the Legislature, neither was based on actual system experience with the new provision, since it was not effective until July 1, 2002. At the time the ROC report was released, ROC indicated that it planned to revisit the projected cost of the multiple employment provision after actual experience with the benefit accrued.

In the meantime, policymaker and stakeholder interest in the impact of the multiple employment provision and in the SIF continued. In the 78th regular legislative session in 2003, legislation was filed to eliminate the multiple employment provision, essentially returning the system to pre-HB 2600 law regarding what income could be counted toward an injured employee's AWW. This bill (HB 2057, 78th regular session) did not pass, but demonstrates the ongoing concern about the potential cost of the provision. In contrast, labor interests remain very supportive of allowing consideration of all IRS-reportable wages in calculating the AWW.

Purpose of Project

This article represents the results of the first attempt to analyze the frequency and cost of the multiple employment provision of HB 2600, and its potential impact on the SIF, based on actual experience. It summarizes the results of a survey distributed in June 2003 to insurance carriers writing workers' compensation policies in Texas, ROC analysis of limited TWCC claims data information on the frequency of multiple employment-related claims and disputes, and utilizes the analysis completed for the August 2002 ROC report.

Copies of the survey were distributed through the Austin representatives of each carrier that was part of one of the 25 largest workers' compensation carrier groups in Texas, based on Texas Department of Insurance statistics.[10] Collectively, these 25 groups represent almost 90 percent of the workers' compensation market. Because this list includes only private insurance carriers, ROC also surveyed large public entity insurance carriers.

The survey asked insurance carriers several questions regarding their experience with the multiple employment provision between July 1, 2002 and April 30, 2003 (the first ten months the provision was effective). Key questions included:

- How many claims the company received involving injured employees seeking income benefits from wages based on multiple employment (i.e., multiple employment claims);
- The total dollar value of the additional income benefit payments made by the company on these multiple employment claims;
- The method(s) by which the carrier tracked multiple employment claims;
- How many multiple employment claims the carrier denied; and

- How many requests for SIF reimbursement of income benefit costs based on multiple employment claims the carrier submitted to TWCC.[11]

Number of Multiple Employment Claims

In projecting the number of workers' compensation claims that would involve benefits based on multiple employment for its August 2002 report, ROC considered several factors. The percentage of employees with multiple jobs in the Texas workforce was projected for each year from 2002 to 2007, and this percentage (somewhere between 4.5 and 4.9 percent of the workforce) was applied to the projected number of employees who would qualify for income or death benefits in these years.[12]

In addition, four "types" of multiple employment were considered, for purposes of projection, since the additional income benefits available would vary for each type: those at which a claimant works two full-time jobs; two part-time jobs; one part-time and one full-time job -- injured on the part-time job; and one part-time and one full-time job -- injured on the full-time job. As noted previously, "learning curve" models were applied to these projections in order to more realistically consider how the benefit may diffuse through the population of potentially eligible injured employees.

Table 3 depicts the August 2002 ROC projections of the number of injured employees who would successfully claim additional benefits based on multiple employment and the projected cost of these benefits in a given year, with consideration of a four-year "learning curve" to model actual utilization. Totals for 2002 are much lower than subsequent years because only during two months of that fiscal year could injured employees claim benefits based on multiple employment. The growth of claims in subsequent years represents only the effects of the learning curve.

ROC's June 2003 survey of insurance carriers regarding multiple employment claims yielded responses from carriers representing approximately 40 percent of the total Texas workers' compensation private market. This percentage does not include another response received from a large public entity insurance carrier. Of those carriers responding who were currently writing workers' compensation policies in Texas, approximately 73 percent indicated they had a system in place to track claims for additional benefits based on multiple employment. In gener-

Table 3
Projected Number of Claims for Benefits based on Multiple Employment and Additional Benefit Costs (2002-2007)
From August 2002 ROC Projections, Four-Year Learning Curve

	2002	2003	2004	2005	2006	2007
Projected # of successful benefit claims*	91	1,263	3,020	4,370	4,596	4,575
Individual injured employees claiming additional benefits**	68	947	2,404	3,276	3,445	3,429
Projected total additional benefits paid in fiscal year***	$102,640	$3.4 mill.	$8.8 mill.	$14.3 mill.	$16.9 mill.	$17.9 mill.

Source: *The Multiple Employment Provision of HB 2600 and its Impact on the Subsequent Injury Fund*, Research and Oversight Council on Workers' Compensation, August 2002.

Notes: * These totals do not represent the number of workers who will claim benefits, but the number of instances in which any of the five types of benefits considered in the analysis (Temporary Income Benefits (TIBs), Impairment Income Benefits (IIBs), Supplemental Income Benefits (SIBs), Lifetime Income Benefits (LIBs), and Death Benefits (DBs)) will be claimed, since more than one type of benefit may be received by an injured employee.

** These totals represent the number of individual injured employees projected to be involved in claims for additional benefits based on multiple employment. It is included only for purposes of comparison to the 2003 survey findings, since these findings reflect individual workers rather than the instances in which one of the five benefit types would be claimed.

*** These totals represent the amount of additional benefits that would be paid by insurance carriers in the given fiscal year, rather than the potential liability for additional benefits paid that may occur over the life a claim. These annual cost figures are more relevant to the balance of the SIF, since the SIF will only make reimbursements as benefits are paid by insurance carriers and submitted for reimbursement, not in advance.

al, carriers were about evenly split between those who described these systems as automated, versus those who indicated that hard copy files were used for this information, although the descriptions of these systems varied widely from one carrier to the next, and several combined elements of automated and paper file systems.

The results of the survey suggest significantly lower utilization of the multiple employment provision during the first ten months of implementation than was projected in any of the previous forecasts. Those carriers responding to the survey reported only 30 claims involving additional income benefits based on the multiple employment provision; assuming this relative frequency generally holds true over the remainder of insurance carriers, then approximately 100 claims based on multiple employment would have occurred during the first ten months the provision was effective.[13]

Cost of Multiple Employment Claims and SIF Implications

Only a portion of those carriers responding to the survey who indicated they had paid additional benefits based on the multiple employment provision were aware of the *amount* of additional benefits they had paid. Of the 30 claims reported, only 15 could be identified with specific additional benefit costs. These data alone were not considered sufficient to project over the whole system in estimating the cost of multiple employment-based claims that have occurred thus far. Therefore, ROC relied instead on the projected cost per claim from the August 2002 study, which took into account all possible types of claims for additional benefits. The ROC's 2002 projections of the average cost per claim for fiscal years 2002 and 2003 was approximately $2,650 per claim, and ROC used this figure to project the cost per claim for the estimated 100 claims in the system between July 1, 2002 and April 30, 2003.

As noted previously, even under the most conservative projections (i.e., those projecting low utilization of the multiple employment provision, such as the four-year learning curve), it appeared unlikely that the SIF could sustain full reimbursement of insurance carriers in the long term – past FY 2008, for example. Table 4 shows the August 2002 projection of the cost and SIF impact of the multiple employment provision, with a four-year learning curve considered.

Based on the early utilization of the provision suggested by the June 2003 survey, the idea that the SIF is not a sufficient source of reimbursement even on a longer term basis may be an open question.[14] Certainly, the survey results suggest that *initial* utilization of the multiple employment provision is much lower than projected in any previous analysis, for reasons that are not entirely clear.

The implications for the SIF of those multiple employment claims made through April 30, 2003 are slight, only about $265,000, less than the interest the SIF earned during that time period. The lower than expected utilization thus far also suggests than the ROC's learning curve assumptions may have overestimated the initial awareness of

Table 4
Projected SIF Revenues, Expenditures, and Year-end Assets – Four-year "Learning Curve" applied to Multiple Employment Utilization
August 2002 ROC Projections

	FISCAL YEAR					
	2002	2003	2004	2005	2006	2007
Revenue: SIF death benefits	$4.5 mill.	$4.8 mill.	$4.8 mill.	$5.0 mill.	$5.1 mill.	$5.3 mill.
Revenue: Interest	$1.0 mill.	$1.2 mill.	$1.2 mill.	$741,211	$327,287	($189,423)
SIF LIBs liabilities (reserved)	$9.5 mill.	$10.2 mill.	$10.8 mill.	$11.3 mill.	$11.8 mill.	$12.4 mill.
Expenditures: Carrier reimbursement, non multiple employment	$942,642	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.1 mill.
Expenditures: Multiple employment reimbursements	$0	$0	$3.5 mill.	$8.8 mill.	$14.3 mill.	$16.9 mill.
Estimated year-end available assets (cash value)	$22.6 mill.	$25.9 mill.	$26.2 mill.	$21.7 mill.	$11.2 mill.	($2.1 mill)
Estimated year-end available assets (present value)	$23.1 mill.	$26.9 mill.	$27.6 mill.	$23.7 mill.	$13.7 mill.	$741,603

Source: Research and Oversight Council on Workers' Compensation, 2002.

the provision among potential eligible injured employees. In order to project the cost of the benefit and impact on the SIF based on the apparent low initial utilization, ROC revised its original August 2002 learning curve to demonstrate potential impact based on current available data. Table 5 shows the results.

Under such a scenario, given current obligations and income for the SIF, the fund would sustain reimbursements even longer than projected previously, likely through FY 2008 and possibly into FY 2009. In fact, the SIF's projected year-end balance in FY 2006 would be only slightly lower than its year-end balance in FY 2003, and it would not be until FY 2006 that the multiple employment obligations would do much more than simply mitigate the growth of the fund.

The scenario shown in Table 5 also includes revisions to the caps on weekly income benefits used to calculate the amount of additional benefits available to injured employees and the way interest accrues to the SIF. These changes are based on additional information about the current and future levels of these factors (i.e., lower caps on benefits and lower interest rates) than were assumed at the time of the August 2002 analysis. The changes are described more fully in the footnotes to Table 5.

As to the overall accuracy of the August 2002 forecast, it is also worth noting that the ROC's projected year-end balance for the SIF at the end of FY 2003 of about $36.1 million is extremely close to the actual balance in the fund. As of the end

Table 5
Projected SIF Revenues, Expenditures, and Year-end Assets – Revised Based on Actual Multiple Employment Utilization
July 1, 2002 to April 30, 2003

	FISCAL YEAR					
	2002	2003	2004	2005	2006	2007
Revenue: SIF death benefits	$4.5 mill.	$4.8 mill.	$4.8 mill.	$5.0 mill.	$5.1 mill.	$5.3 mill.
Interest*	$1.0 mill.	$1.2 mill.	$520,729	$620,230	$523,102	$470,882
SIF LIBs liabilities (reserved)	$9.5 mill.	$10.2 mill.	$10.8 mill.	$11.3 mill.	$11.8 mill.	$12.4 mill.
Expenditures: Carrier reimbursement, non multiple employment	$942,642	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.1 mill.
Expenditures: Multiple employment reimbursements**	$0	$0	$955,719	$3.0 mill.	$7.6 mill.	$12.4 mill.
Estimated year-end available assets (cash value)	$22.6 mill.	$25.9 mill.	$27.7 mill.	$28.1 mill.	$24.0 mill.	$15.3 mill.
Estimated year-end available assets (present value)	$23.2 mill.	$26.9 mill.	$29.0 mill.	$29.7 mill.	$25.9 mill.	$17.5 mill.

Source: Research and Oversight Council on Workers' Compensation, 2003.
Notes:
*Since it is now considered an account in the state's general revenue fund, the office of the State Comptroller of Public Accounts has informed TWCC that the interest earned by the SIF will no longer be credited to the SIF. Assuming this remains the case, the interest earned by the SIF does not benefit the SIF specifically but rather the state's general revenue. Accordingly, in this projection, interest for years FY 2004 and forward is not added to the SIF's balance.

Based on changes in the percentage of interest the SIF currently is earning and is expected to earn in coming years, ROC revised the interest assumptions used in this projection for the years post-FY 2003. In the August 2002 forecast, a constant five percent interest rate was assumed; for this forecast, a two percent interest rate was assumed for FY 2004, with a half percent increase in each of the next three years. Since the interest income will no longer be credited to the balance of the SIF, this change does not impact the SIF's projected balance.

** For FY 2003, ROC's revised learning curve assumed a somewhat higher utilization of the multiple employment provision that the initial data suggest. For FY 2003, the learning curve shown in Table 5 assumes about 230 injured employees making claims for additional benefits, rather than the 130 or so suggested by the survey results. ROC considered this justified based on the likelihood that claims will increase over time and a desire to be conservative in projecting the potential burden on the SIF, erring on the side of overestimating rather than underestimating claims. Until more complete data is available for all of FY 2003 (and beyond), and long-term trends can be established, this seemed the most logical way to reexamine the learning curve.

Aside from the revised utilization of the multiple employment provision and the adjustment in the interest assumptions explained above, one other aspect of the August 2002 projections was revised for this projection. The weekly caps on benefits projected in August 2002 were significantly higher than the actual caps will be in FY 2004 and 2005, and will likely be even higher in FY 2006 and 2007. The caps for 2004 and 2005 are set at $537 and $539, respectively, by statute (see Texas *Labor Code* Section 408.047, as revised by SB 1574, 78th Regular Session). Since the caps projected for FY 2006 and 2007 are based on trends from recent years, lowering the caps in 2004 and 2005 also lowered the projection for those years. The result is a decrease in the projected cost of the multiple employment provision, since more workers would have their additional benefits limited by the lower cap. The effect is not insignificant, particularly in the latter years of the projection, where the lower expected cap reduces the expected cost of the provision by about $1.5 million.

of May 2003, TWCC calculated this balance at about $36 million.

Claims Denied and Disputes

In addition to claim incidence and costs, the survey asked carriers whether or not they had denied any claims for multiple employment-based income benefits. Only one denied claim was reported among the carriers responding. To further consider the frequency of multiple employment-related denials and disputes, ROC examined the occurrence of "dispute codes" associated with these issues in the TWCC Dispute Resolution Information System (DRIS).

Through early July 2003, seven disputes in the TWCC admin-

Scarce Data Suggest Initial Pharmacy Provision Unlikely to Impact SIF

Another HB 2600 statutory change involved the medical benefits – specifically, pharmaceutical benefits – available to injured employees during the period just after an injury. Some policymakers were concerned that uncertainty about the status of an employee's claim, and even whether the employer carried workers' compensation coverage or not, could make pharmacists less likely to fill prescriptions during the initial stages of a claim. A 2001 statutory change allowed TWCC to provide by rule that an insurance carrier shall pay for pharmaceutical services sufficient for the first seven days of a claim if the health care provider (typically, the pharmacist) requests and receives verbal confirmation of workers' compensation coverage and the report of an injury, from either the insurance carrier or the employer. Carriers who pay these initial benefits for claims later determined to be non-compensable (i.e., not to have occurred in the course and scope of work) may apply to the SIF for reimbursement of these costs. TWCC rules implementing these changes are effective for dates of injury on or after November 7, 2002.

Earlier SIF forecasts, including the ROC's August 2002 projections and TWCC's February 2003 actuarial report, treated these pharmacy reimbursement costs as negligible. Although pharmacy costs on a workers' compensation claim can be very significant, it was assumed that the amount paid for drugs sufficient for just the first seven days is typically not a large amount of money. Based on the information available at this point about the use of this provision from the same June 2003 carrier survey used to inquire about the multiple employment claims and TWCC data, these seem to have been safe assumptions. Slightly less than two-thirds (7 of 11) of the carriers responding to the survey who were currently writing workers' compensation policies indicated that they had some system in place to track instances of pharmacy payments for non-compensable claims. Only one respondent reported specific numbers of claims and associated costs; another indicated a range of potential claims and costs. The remaining respondents were evenly split between those reporting no such claims and those that did not know.

For the two carriers responding with some specific information, 30 to 35 such claims were reported at a total cost of less than $1,000. Given the extent of this information, it is not possible to project with any degree of reliability the overall system costs that may be associated with the initial pharmaceutical provision. As of mid-July 2003, TWCC indicates it has received no requests for reimbursements from the SIF based on this provision. Continued monitoring of the SIF during the next year or so (as more claims have the opportunity to be deemed non-compensable) should reveal whether this provision is likely to account for any significant cost to the SIF. At this point, it appears a safe assumption to regard these costs as negligible to the SIF.

istrative process were coded as related to multiple employment issues at the initial dispute resolution level, an informal mediation known as a Benefit Review Conference (BRC). Two of these disputes related to the entitlement to multiple employment benefits, and five to the amount of the AWW of the employee claiming multiple employment benefits. Five of these disputes were reported resolved, two in favor of the injured employee and three by mutual agreement.[15] One of the two BRC disputes related to entitlement to benefits had reached the formal adjudication level of a TWCC Contested Case Hearing (CCH), and was found in favor of the insurance carrier at this level.

Although these data are far too scarce and preliminary to draw any conclusions about the outcomes of disputes related to multiple employment issues, the low frequency of disputes is in line with the frequency of claims reported by carriers – although, as noted, only one of the carriers surveyed reported a denial.[16]

Conclusion

The most striking result of this survey is the low apparent incidence of multiple employment claims reported by insurance carriers for the first ten months of the provision's effect, a finding supported by available TWCC claims data. Utilization of the benefit has been so low that reimbursements of carriers for related income benefit costs based on these claims are likely to be less than $300,000.

The exact reasons for this lower than expected utilization are unclear, but several possible explanations present themselves as most likely. One is that injured employees are less aware of the benefit than was assumed in the learning curve models, and that in some cases where they are aware, the additional benefits available may be perceived as not enough to justify the effort.[17]

Another possibility is that some insurance carriers are not aware of whether they are paying additional benefits based on multiple employment or not. It is significant to note that a quarter of carriers responding to the survey reported no method for tracking multiple employment claims, and that even some of those who did track such claims were not aware of the amount of additional benefits that had been paid.

It is far too early, however, to conclude that the multiple employment provision will not have a significant long-term impact on the SIF. Assuming that the prior explanations largely account for the paucity of claims thus far, important caveats must be considered. For one, knowledge about the benefit among injured employees will only increase for future claims, and there is nothing necessarily to prevent even those with older injuries (provided, of course, that they occurred on or after July 1, 2002) later claiming enhanced benefits based on multiple employment status prior to the injury. The original four-year learning curve model, while projecting higher utilization of the benefit initially than has been borne out, also projected a sharp escalation in utilization between FY 2003 and 2004, and again between FY 2004 and 2005, with some leveling off after this point. If employees make more claims in future years, carriers also will have additional incentive to improve their tracking of such claims in order to successfully pursue reimbursement.

ROC's revised learning curve (see Table 5) is an attempt to more realistically model growth in the utilization of the benefit based on very limited information, and should not be regarded as definitive of the future impact in terms of cost or impact on the SIF. Indeed, at this juncture, based on available information, no analysis could reasonably do so. In short, the apparent very low initial utilization of the benefit should not be interpreted to mean that it will *never* be utilized by a significant percentage of the eligible injured employees. It is simply too early to tell if this will be the case or not.

One final implication of the findings of this project is that it may not be sufficient on a long-term basis to rely on survey data to evaluate and project the utilization of the multiple employment provision, and thus the possible impact on the SIF. It is impossible to conclude from the results of this or any other survey whether the results truly indicate very low utilization of the benefit, insurance carrier uncertainty about the use of the benefit, or

both. TWCC-collected data, against which to test the validity of carrier reports, are also limited.

Such uncertainty was already problematic in projecting the future implications for the SIF, but the re-designation of that fund as a dedicated general revenue account by the 78th Legislature – and the likelihood that appropriations requests will be required one and two years in advance in future years – makes better data collection to estimate future liabilities even more necessary, if the SIF is to be properly prepared for its potential obligations.

Notes to pages 7-15

[1] In fiscal year 2003 (Sept. 1, 2002 to Aug. 31, 2003) the statutory cap on Temporary Income Benefits (TIBs), the chief lost-wage benefit in the Texas workers' compensation system, is $536. For FY 2004, this cap will be $537, and for FY 2005, $539, in accordance with the provisions of Senate Bill 1574 (78th Legislature, 2003). Weekly caps for Lifetime Income Benefits (LIBs) and Death Benefits (DBs) are also capped at the TIBs levels; caps for Impairment Income Benefits (IIBs) and Supplemental Income Benefits (SIBs) are capped at 70 percent of the TIBs level.

[2] Prior to 1989, language in the Texas workers' compensation statute related to "same or similar" employment by an injured employee led to court interpretations that allowed for some consideration of multiple employment in income benefit levels. See ROC online publication *Multiple Employment in the Texas Workers' Compensation System: Features and Benefits*, August 2001, available online at http://www.roc.state.tx.us/Multiemp.htm for more details on pre-1989 multiple employment-related workers' compensation system features.

[3] The total amount of weekly income benefits an employee receives are still limited by statutory caps, regardless of whether multiple employment is present or not.

[4] Prior to the 78th regular legislative session, the SIF was statutorily described as a "special fund in the state treasury." The fund was managed by TWCC, and did not require a specific legislative appropriation in order to expend funds, as do state agencies and other general revenue funds. After legislative action in the 78th session, two bills (HB 3318 and HB 3378) passed that changed the SIF into an account in the general revenue fund. This change will likely require in the future that TWCC or whatever agency administers the fund request and receive a specific legislative appropriation for the projected expenditures of the SIF.

[5] LIBs are available only for specific, severe injuries described in *Texas Labor Code* Section 408.161.

[6] See Texas *Labor Code* Section 403.007. Historically, interest income earned by the SIF has been credited to the SIF's balance. However, based on the changes made during the 78th regular legislative session discussed previously, the future interest earned by the SIF will be credited to the state's general revenue as a whole, and not to the SIF specifically.

[7] See Texas *Labor Code* Section 403.007 (e).

[8] See *The Multiple Employment Provision of HB 2600 and its Impact on the Subsequent Injury Fund*, Research and Oversight Council on Workers' Compensation, August 2002.

[9] See *Actuarial Analysis of the Texas Workers' Compensation Subsequent Injury Fund*, Mercer Risk, Finance and Insurance Consulting, February 2003.

[10] Workers' compensation carrier group rankings were taken from the most recent TDI Quarterly Legislative Report on Market Conditions available at the time the survey was distributed. This report is available online at http://www.tdi.state.tx.us/general/forms/tdirpts.html#qtr.

[11] As of mid July 2003, TWCC reported it had received four requests for reimbursement from carriers, with total reimbursement of $9,127.64 requested. TWCC's policy on carrier reimbursements for multiple employment-based benefits calls for no reimbursements to be made until October 2003 (early in FY 2004); see TWCC Rule 116.12. It is important to note that the small amount of reimbursement requests received so far does not mean that significantly more requests will not be made later. Carriers may file for reimbursement in the same or the next fiscal year in which payment was made, and carriers have little incentive to have filed their requests by this point, because they will not be paid until at least October 2003, anyway.

[12] These projections were based on Bureau of Labor Statistics (BLS) Texas survey data for the years 1994 to 2000 (unpublished); based on historical patterns, the rate of multiple employment among the Texas workforce was projected at 4.85 percent in 2002, and projected to decrease slightly over time (to a low of 4.54 percent in 2007). The projected percentage of multiple employment in the workforce was then applied to the projected number of employees eligible for each type of workers' compensation income or death benefit in a given year, based on historical data from the TWCC System Data Report (SDR). Multiple employment was not assumed to be more or less frequent among injured employees than among the state's workforce in general. See *The Multiple Employment Provision of HB 2600 and its Impact on the Subsequent Injury Fund*, Research and Oversight Council on Workers' Compensation, August 2002.

[13] This estimate is based on the survey data reporting 30 claims by insurance carriers representing approximately 40 percent of the private workers' compensation market and one large public entity insurance carrier. The estimate in this report of 100 overall claims based on multiple employment assumes that these carriers represent 25 to 30 percent of the total workers' compensation *system* (including private carriers, public entity carriers, and self-insured employers). In an attempt to validate the numbers reported by insurance carriers on the survey, ROC also considered the number of forms filed with TWCC claiming additional benefits based on multiple employment (TWCC 3-MEs). Through the end of June 2003, 21 valid (i.e., non-duplicate, and with injury dates on or after July 1, 2002) forms had been re-

ceived. ROC review of these forms indicated that eight were identified with insurance carriers that responded to the June 2003 survey. Although it is important to keep in mind the numbers involved are very small (less than 25 claims), the fact that 30 to 40 percent of the claim forms that TWCC has received are related to carriers that responded to the survey suggests also that the actual number of claims systemwide is approximately two and a half to three times the 30 reported by carriers responding to the survey, or roughly 100 claims.

[14] Any analysis in this article of the adequacy of the SIF to sustain reimbursements assumes no additional obligations are placed on the fund. Now that the SIF is a fund in the state's general revenue account, attempts to use its unencumbered balance for other purposes are possible.

[15] No disposition was indicated for the remaining two disputes. However, a review of the specific DRIS records for these claims indicates that one dispute was withdrawn because the carrier involved agreed to pay additional benefits, and the other was resolved by agreement of the carrier and injured employee.

[16] A ROC check of the disputed claims in the DRIS system showed that only one of the claims in dispute involved carriers that responded to the survey. This not only helps to validate the responses to the survey (since these carriers collectively reported only one dispute), but also suggests that carriers *not* responding to the survey have experienced claims for additional benefits based on the multiple employment provision.

[17] It is also possible that the percentage of multiple employment seen in the general workforce (according to the BLS data mentioned previously) does not translate well to the population of injured employees. However, there is nothing to suggest that this is the case, and the percentage of multiple employment would have to be much lower in order to account for much of the lower than expected claims volume.

Measuring Interest in a 24-Hour Coverage Pilot

A Survey of Texas Employers and Insurers Who Write Workers' Compensation Policies

by Andrew Moellmer

A basic goal of the workers' compensation system is to provide quality medical care at a reasonable cost to workers who are injured on the job. In the early 1990s, as medical and administrative costs escalated rapidly, many states began looking for new ways to reduce workers' compensation costs while preserving the quality of care delivered to injured workers.

One common approach was to test programs that would bridge the traditional gap between occupational and non-occupational insurance coverage. Dubbed "24-hour coverage," such programs combine workers' compensation with other employee benefits, such as group health coverage and disability insurance. These programs can encompass a variety of insurance products, ranging from basic coordination of workers' compensation and group health claims, to a single global policy that includes coverage for all injuries and diseases, including the provision of indemnity benefits, regardless of whether workers' medical conditions are occupational or non-occupational in nature.[1]

Twenty-four hour coverage can provide administrative and medical savings through eliminating double-billing among various health plans, allowing for the marketing of a single insurance product by insurance carriers, and integrating management of an employer's group health and workers' compensation insurance claims. It may also improve the quality of care and increase patient satisfaction by reducing coverage gaps, and offering workers the ability to use the same treating doctor for occupational and non-occupational injuries and diseases.[2]

With the advantages of bridging the gap between occupational and non-occupational injury coverage come some concerns. 24-hour coverage may endanger "exclusive remedy"[3] protection for employers if the lines be-

tween occupational and non-occupational illness and injury are not as clean. Similarly, there are concerns that creating a hybrid system that merges coverages might lead to efforts to introduce employee deductibles and co-pays into workers' compensation coverage, thereby reducing the benefits available to injured workers. Other concerns noted in the literature include: ambiguities relating to possible federal regulation of workers' compensation coverage under ERISA provisions;[4] concerns regarding the determination of claim compensability for workers' compensation purposes under an integrated benefits system; potential for increased regulatory conflict between state insurance departments and workers' compensation agencies over jurisdictional matters; the inability of smaller carriers that prefer to specialize in a single line of insurance to compete effectively in a multiple line insurance market; and the possibility that total health costs could increase if the group health part of the program takes on characteristics common to more expensive workers' compensation insurance, such as higher caps on medical fees in some cases, no dollar limits on care, and coverage beginning on the first day of employment.[5]

Although many states have passed enabling legislation authorizing pilot projects to study the effectiveness of 24-hour coverage programs, to date only California, Minnesota, Washington, and New York have carried their pilot projects through to the evaluation phase. Evaluation of these programs resulted in mixed findings on such measures as patient satisfaction and cost effectiveness.[6] For example, in California medical claim costs increased, while in Washington and New York claim costs fell. Patient satisfaction increased in New York and Minnesota, but declined in Washington.

Other states (including Florida, Georgia, Kentucky, Louisiana, Oregon, Oklahoma and Maine) adopted enabling legislation in the early 1990s to implement 24-hour pilot programs, but evaluation of these programs has yet to be undertaken. Many of these programs never entered the implementation stage due to lack of a sufficient number of participants. The primary reason for this is that by the mid-1990s, the time when many states began to implement 24-hour coverage pilots, the workers' compensation insurance market became more competitive leading to lower insurance premiums for employers. Interest in cost-effective alternatives to traditional workers' compensation insurance began to wane accordingly.[7]

Conditions in the workers' compensation insurance market have changed significantly in recent years. Previous studies conducted by the Research and Oversight Council on Workers' Compensation (ROC) indicate that since the late 1990s there has been a significant growth in the percentage of Texas employers experiencing an increase in their workers' compensation premiums.[8] Additionally, during the same period, insurance carriers have reported declining profitability of their workers' compensation lines of insurance.[9] Similar to the late 1980s and early 1990s, these developments may make non-traditional means to deliver health and indemnity benefits to injured workers (and reduce costs) more attractive to participants in the Texas workers' compensation system. This article presents the results of surveys of Texas employers and insurance carriers writing workers' compensation in Texas to gauge their interest and attitudes about 24-hour coverage programs.

Data and Methods

Data were collected for this article by distributing surveys to a random sample of 3,110 firms with workers' compensation policies and 390 nonsubscribing firms,[10] for a total sample of 3,500 Texas employers. The surveys were followed by postcards containing a reminder and contact information if employers needed another copy of the survey. Surveys were also distributed to the 25 largest insurance groups (representing a total of 167 insurance carriers) via their Austin representative mailboxes at the Texas Workers' Compensation Commission (TWCC) central office. Reminder postcards and emails were also sent to each of the carrier groups.[11]

Inaccurate address information in the database prevented the delivery of survey materials to 310 employers. This left a total sample of 3,190 Texas employers that actually received a

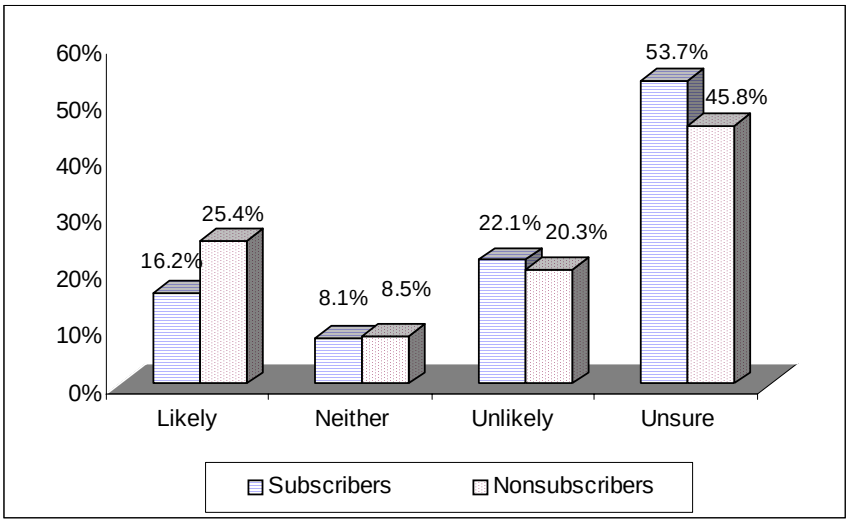
survey. Surveys were received from 298 Texas employers, for an overall response rate of 9.3 percent.[12] Approximately 52.7 percent of the responses came from subscribing firms while the remaining 47.3 percent came from nonsubscribing firms.[13]

The response rate for insurance carriers was much lower. Responses from seven private market carrier groups and one carrier representing public entities are included in the results. Overall, those private carrier groups who responded represent approximately 32 percent of the workers' compensation insurance market in Texas. Given the low number of responses from carriers, results based on their opinions should be viewed as tentative and exploratory in nature.

The following research questions are addressed in this article:

- How much interest is there among Texas employers and insurance carriers in a 24-hour coverage Pilot Program?
- What type of program is most appealing to employers and carriers?
- What perceptions do employers and carriers have about the effects of 24-hour coverage programs on workers' compensation and group health costs?
- What are the demographic characteristics of employers and carriers that are associated with interest in a 24-hour coverage pilot?

Figure 4
Likelihood of Participating in a 24-Hour Coverage Pilot, by Employer Subscription Status



Source: Research and Oversight Council on Workers' Compensation, 2003.

Texas Employer Interest in a 24-Hour Coverage Pilot Program

Employers were asked a series of questions to measure their interest in participating in a 24-hour coverage pilot in Texas. A larger proportion of nonsubscribing (25 percent) than subscribing (16 percent) firms said they would be likely to participate if a 24-hour coverage pilot were implemented in Texas (see Figure 4).

When asked what type of 24-hour coverage pilot would be most appealing, approximately one-fifth (21 percent) of all subscribing firms said 24-hour medical and disability coverage for all injuries and diseases was the most appealing option, while a similar proportion (20 percent) found integrated claims management of existing workers' compensation and group health claims to be appealing (see Table 6). Over one-third (37 percent) of subscribing firms said that none of the options is appealing.

Among nonsubscribing firms, one fourth (26 percent) indicated that 24-hour medical and disability coverage for all injuries and diseases is the most appealing option. A mere 5 percent of these employers said that integrated management of existing workers' compensation and group health claims is appealing, while 42 percent of nonsubscribing firms said none of the options are appealing. Interestingly, over half (53 percent) of nonsubscribing firms show interest in some form of a single 24-hour coverage policy that offers coverage for both occupational and non-occupational injuries and/or diseases. These findings suggest that nonsubscribing firms may be more interested in a more comprehensive single 24-hour coverage policy in some form, as distinct from the joint coordination of benefits under separate policies, as is the

Table 6
Preferred Type of 24-Hour Coverage Pilot, by Workers' Compensation Subscription Status

Type of Coverage	Subscribers	Nonsubscribers
Integrated claims management	20%	5%
24-hour medical coverage for all injuries and diseases	9%	11%
24-hour disability coverage for all injuries and diseases	4%	3%
24-hour medical and disability coverage for all injuries	8%	13%
24-hour medical and disability coverage for all diseases	1%	1%
24-hour medical and disability coverage for all injuries and diseases	21%	26%
None	37%	42%

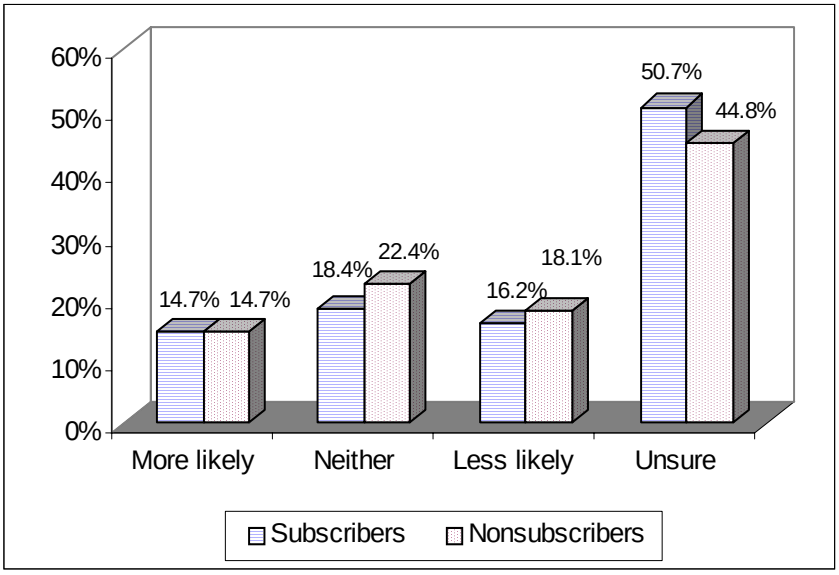
Source: Research and Oversight Council on Workers' Compensation, 2003.

case in the integrated claims management option, than firms with workers' compensation coverage.

Employers were also asked questions to determine whether their interest in a 24-hour coverage pilot would increase based on several insurance-related policy issues. First, employers were asked whether they would be more likely to participate if the pilot were to require injured workers to enroll in a network of providers for their occupational health care. Employers were asked their opinion regarding whether the incorporation of a network of providers into a 24-hour coverage pilot would make them more likely to participate in a 24-hour coverage pilot (see Figure 5). Approximately 16 percent and 18 percent of subscribing and nonsubscribing firms, respectively, said that such a provision would make them less likely to participate. Approximately one-half of subscribers (51 percent) and slightly fewer nonsubscribers (45 percent) were unsure whether their participation would be either more or less likely. Given the high degree of uncertainty expressed by employers, and the comparatively few employers who say a provider network will make their participation more likely, it is difficult to predict the likely effect such a provision might have on employers.

There is less ambiguity concerning the issue of employer choice of provider. Employers were asked if adopting an employer choice of provider model in Texas would make them more likely to participate in a 24-hour coverage pilot. One fourth of subscribing firms (25 percent) indicated that they would be more likely to participate if an employer choice model were adopted, as compared to 22 percent of nonsubscribing firms (see Figure 6).[14] Approximately twice as many nonsubscribing (14 percent) as subscribing (7 percent) firms said they would be less likely to participate. Once again, the proportion of those employers who are unsure about whether their participation would be more or less likely is high for both subscribing (51 percent) and nonsubscribing (45 percent) firms. These findings suggest that there is a greater likelihood that adopting an employer choice model in Texas will increase participation

Figure 5
Likelihood that Incorporating a Health Care Network Would Increase Participation in a 24-Hour Coverage Pilot, by Employer Subscription Status



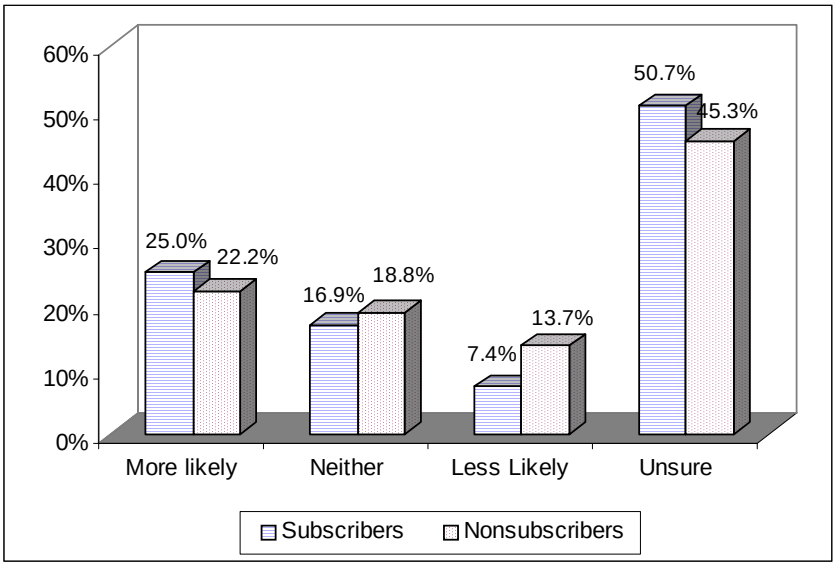
Source: Research and Oversight Council on Workers' Compensation, 2003.

in a pilot, particularly among subscribers, as compared to the greater ambiguity of the effect of adopting a network of providers on employer participation.

Finally, employers were asked their opinions about the likely effect of 24-hour coverage on workers' compensation and group health costs. Over one-quarter of subscribing firms (28 percent) and slightly more than one-fifth of nonsubscribing firms (21 percent) believe that 24-hour coverage would increase overall workers' compensation costs (see Figure 7). Only 8 percent of nonsubscribing firms think that workers' compensation costs would decrease while a mere 4 percent of subscribing firms believe this. A similar proportion of subscribing (62 percent) and nonsubscribing (65 percent) firms are unsure about the effect of 24-hour coverage on workers' compensation costs. These findings suggest that employers generally perceive little positive cost benefit of 24-hour coverage as it applies to workers' compensation cases.

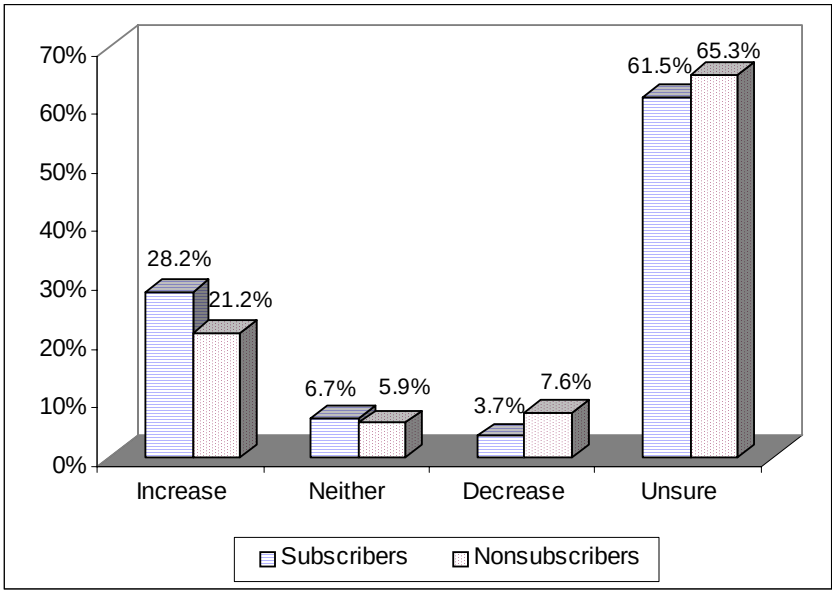
In terms of group health costs, subscribers and nonsubscribers are largely in agreement. Approximately one-fifth of both subscribing (19 percent) and nonsubscribing (22 percent) firms think 24-hour coverage will increase group health costs (see Figure 8). A much smaller percentage of subscribing (7 percent) and nonsubscribing (6 percent) firms believe that group health costs would decrease. As before, almost two-thirds of both subscribing (63 percent) and nonsubscribing (62 percent) firms are unsure what the effects of 24-hour coverage on group health costs would be. Similar to the findings for the effect on workers' compensation costs, it seem Texas employers perceive little positive cost benefit of 24-hour coverage as it applies to group health.

Figure 6
Likelihood that Adopting an Employer Choice Model in Texas Would Increase Participation in a 24-Hour Coverage Pilot, by Workers' Compensation Subscription Status



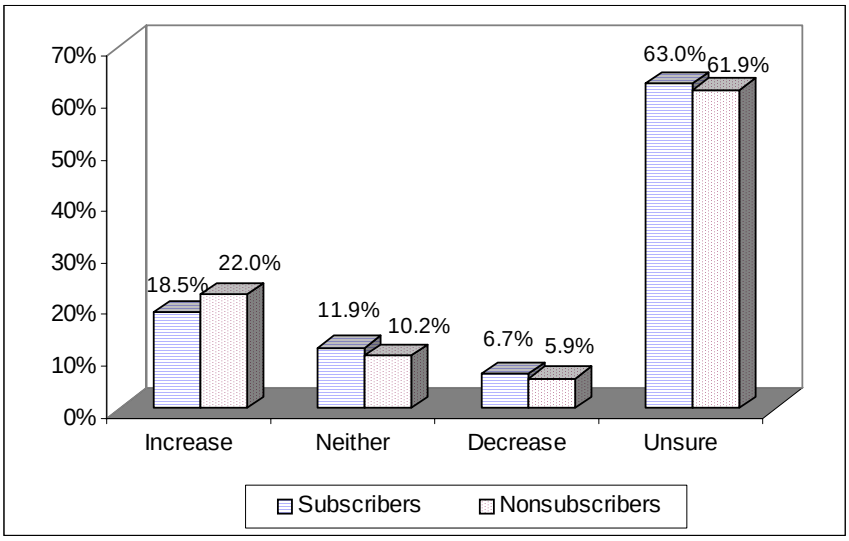
Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 7
Perceived Impact of 24-Hour Coverage on Workers' Compensation Costs, by Employer Subscription Status



Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 8
Perceived Impact of 24-Hour Coverage on Group Health Costs, by Employer Subscription Status



Source: Research and Oversight Council on Workers' Compensation, 2003.

Insurance Carrier Interest in a 24-Hour Coverage Pilot

For this article, the ROC also surveyed insurance carriers that write workers' compensation policies in Texas. As mentioned earlier, the eight carriers who responded represent approximately 32 percent of the workers' compensation market. These carriers were asked the same series of questions as employers to gauge their interest in a 24-hour coverage pilot. Due to the low response rate among insurance carriers, the results of this analysis should be viewed with caution.

When asked directly how interested they would be to participate in such a pilot, none of the carriers showed any interest in participating. One carrier indicated indifference to the concept while three said they were unlikely to participate. The remainder said they were unsure.

When asked what type of pilot would be most appealing, five of the carriers said "none". This is not surprising given the apparent lack of interest in the 24-hour coverage concept cited above. Two of the carriers said that integrated claims management of existing workers' compensation and group health claims is the most appealing option.

Carriers were also asked the same set of questions as employers regarding insurance-related issues and 24-hour coverage. First, carriers were asked whether incorporating a requirement that injured workers participate in a network of providers would increase their likelihood of participating in a 24-hour coverage pilot. Three of the carriers indicated that they would be more likely to participate if this requirement were adopted.

When asked about whether adopting an employer choice of doctor model in Texas would make their participation in a pilot more likely, only one carrier said this would be the case.

Carriers were also asked to express their opinions on the effect of 24-hour coverage on workers' compensation and group health costs. Three of the carriers indicated that 24-hour coverage would increase overall workers' compensation costs while two carriers said that costs would decrease. The remaining carriers were either neutral or unsure about this issue. There was greater uncertainty about the effects of 24-hour coverage on group health costs. One carrier each said that group health costs would either increase or decrease, respectively, while the remaining carriers said they were either neutral or unsure about this issue.

It should again be noted that only 8 carriers responded to the survey, and although these carriers represent a significant share of the workers' compensation market, none of them write group health insurance in Texas. This in part may explain the greater degree of uncertainty about the effects of 24-hour coverage on group health costs. It also may explain the reluctance of the carriers who responded to participate in a 24-hour coverage pilot since a basic element of such coverage is the integration of workers' compensation and group health claims administration.

Overall, these results suggest that although there is little interest among carriers in partic-

ipating in a 24-hour coverage pilot, interest may be increased if certain provisions are incorporated into the pilot such as requiring workers to participate in a network of providers or adopting an employer choice of provider model in Texas. Of the range of 24-hour coverage alternatives, only a limited form, integrated management of worker's compensation and group health claims, seems to have any possibility of support among the carriers responding to the survey.

Conclusion

It has been suggested that 24-hour coverage programs may be one way to reduce workers' compensation costs and improve the quality of care for injured workers. Whether this can occur in practice has yet to be determined, since the results of pilot programs that have been implemented and evaluated in other states are mixed. This article reports on research conducted through a survey of Texas employers and insurers who write workers' compensation insurance in Texas to gauge the degree of interest in establishing a 24-hour coverage pilot in Texas.

As discussed earlier, there is only modest interest at best for such an initiative among employers. Substantially more nonsubscribing (25 percent) than subscribing (16 percent) firms indicated that they were likely to participate. Most of the employers (58 percent), however, were neutral or unsure about their participation. This suggests that with the right combination of education and policy incentives, more employers may be induced to participate in a pilot program. Underscoring this is the fact that only one in five subscribing and nonsubscribing firms said they were unlikely to participate.

The small number of insurance carriers responding to the survey indicated that they are even less inclined to participate in a 24-hour project. Three of the responding carriers said they were unlikely to participate. Most were either neutral or unsure about whether they were likely to participate. Similar to employers, this ambiguity suggests that with the right mix of education and policy initiatives, some carriers might be induced to participate.

What explains the low levels of interest in a 24-hour coverage pilot? One possible reason is the perception among both employers and carriers (particularly employers) that there is little or no cost benefit to 24-hour coverage, whether in terms of workers' compensation or group health costs. Only 4 percent and 8 percent of subscribing and nonsubscribing firms, respectively, thought that 24-hour coverage would decrease workers' compensation costs. Similarly, only 6 to 7 percent of subscribing and nonsubscribing firms thought that group health costs would be decreased. Carriers were similarly doubtful about the positive benefits of 24-hour coverage in reducing group health and workers' compensation costs.

One way to increase interest in a 24-hour coverage pilot might be to introduce certain provisions such as requiring injured workers to participate in a network of providers or incorporating an employer choice of doctor component into the model. Employers and carriers were asked whether incorporating a network of providers into a pilot would make them more likely to participate. The difference between employers and carriers on this issue is stark. A modest percentage of subscribing (16 percent) and nonsubscribing employers (18 percent) said they would be more likely to participate under this model as compared to more than a third (3 of 8, or 37.5 percent) of carriers who said this. On the other hand, employers would be more likely than carriers to participate if an employer choice component were to be adopted in the pilot. 25 percent and 22 percent of subscribing and nonsubscribing firms, respectively, said this would be the case, as compared to only one of the eight carriers who said this.

These findings suggest that selectively incorporating both components into a pilot might increase participation among both employers and carriers. Both groups may respond more positively to giving them greater control over the choice of provider, whether in the form of a provider network to encourage carriers to participate or an employer choice model to encourage employers to participate.

The fact that none of the carriers responding to the survey indicated that they would be in-

terested in participating in a pilot, as compared to over 20 percent of employers, suggests that adopting provisions designed to encourage carrier participation may be the best approach. Either option would require first amending the Texas *Labor Code*.

Finally, it seems that the most popular aspect of 24-hour coverage overall is integrated claims management of existing workers' compensation and group health claims. One-fifth (20 percent) of subscribing firms, and two of the eight insurance carriers (25 percent) seemed to favor this limited form of 24-hour coverage. Nonsubscribing firms (26 percent) appear to prefer more comprehensive forms of 24-hour coverage, such as 24-hour medical and disability coverage for all injuries and diseases.

In summary, the findings reported in this article suggest that the type of 24-hour coverage pilot that is likely to produce the highest rate of participation among employers and carriers is one that retains separate policies for both workers' compensation and group health coverage, but provides for integrated management of claims. An additional inducement to encourage carrier participation might be the incorporation of a requirement that injured workers choose their treating doctor from a provider network that is selected by the carrier. An integrated management model with a provider network seems to be the most feasible and appealing option for the establishment of a 24-hour coverage pilot in Texas. Given the sensitive nature of any statutory changes related to choice of doctor issues, and the historical separations of workers' compensation and group health coverage, any such provisions would likely have to be carefully crafted and debated, even on a pilot project basis.

Notes to pages 16-23

[1] For a detailed enumeration of the range of 24-hour coverage program options see Workers' Compensation Task Force, "A Progress Report on the Implementation of 24-hour coverage" December 1999 (Kansas City, MO: National Association of Insurance Commissioners).

[2] Hughey, Vance A. "24-Hour Health Care Coverage and Workers' Compensation" Background Paper 97-5 (Carson City, NV: Nevada Legislative Counsel Bureau).

[3] If injured workers file a worker's compensation claim, they are granted no-fault coverage for on the job injuries and diseases, but in exchange must relinquish the right to sue employers unless there is evidence that the employer's negligence contributed to the injury.

[4] Employee Retirement Income Security Act of 1974.

[5] A discussion of the possible obstacles to implementation can be found in Workers' Compensation Task Force, op. cit., and Hughey, op. cit.

[6] See Linda Rudolph et al, "Injured Worker Satisfaction with Care in a 24-Hour Pilot Program" (Sacramento, CA: California Department of Industrial Relations, December 2000); Gerald Kominski et al, "Evaluation of California's 24-hour coverage Pilot Demonstrations" (Los Angeles, CA: UCLA Center for Health Policy Research, November 2001); McGrail, Michael P. et al, "The Minnesota Health Partnership and Coordinated Health Care and Disability Prevention: The Implementation of an Integrated Benefits and Medical Care Model" *Journal of Occupational Rehabilitation*, 12:1 (March 2002), 43-54; Kelly B. Kyes et al, "Evaluation of the Washington State Workers' Compensation Managed Care Pilot Project" *Medical Care* 37:10 (October 1999), 972-993; Borba, Phillip S. and Thomas Parry, "An Evaluation of the Comprehensive and Organized Managed Care Program: Final Report" (Integrated Benefits Institute, 2000); and "Evaluation of the Minnesota Health Partnership: Coordinated Health Care and Disability Prevention Project" http://www.umassmed.edu/workerscomp/grants/grant10.cfm.

[7] Oregon and Maine are two states that experienced initial interest from employers in 24-hour coverage projects, only to see that interest wane due to changing market conditions. See Joseph, Robert E. "24-hour coverage: The Oregon Pilot" FORC *Quarterly Journal of Insurance Law and Regulation* 9:4 (Winter 1997) and Bureau of Insurance, "Maine's 24-hour coverage Pilot Project" Completed Grant Report to the Robert Wood Johnson Foundation, November 1997.

[8] See *Biennial Report of the Research and Oversight Council on Workers' Compensation*, Research and Oversight Council on Workers' Compensation, 2002, pp. 100-104.

[9] Ibid., pp. 105-109.

[10] Texas is the only state where workers' compensation coverage is truly optional. "Nonsubscribing" firms are those that have not purchased this coverage.

[11] These 25 carrier groups represent approximately 89 percent of the Texas workers' compensation market. See Texas Department of Insurance, *Quarterly Legislative Report on Market Conditions: Third Quarter 2002*, 2003 (available at http://www.tdi.state.tx.us/general/pdf/pcqlr02q3.pdf).

[12] Respondents were asked to indicate their preference on a standard Likert Scale, where 1 is "very likely" and 5 is "very unlikely." For the purpose of analysis, a response of 1 or 2 was recoded as 1 "likely," a response of 3 was recoded as 2 "neither likely nor unlikely," and a response of 4 or 5 was recoded as 3 "unlikely."

[13] There is a significant difference in response rates by subscription status. The response rate for subscribing firms was 5 percent. The response rate for nonsubscribing firms was 36 percent.

This disparity in employer survey response rates by subscription status may indicate that nonsubscribing employers were generally more interested in responding to a survey examining coverage alternatives than subscribing employers. While the final results of this study should not be considered representative of the interest in 24-hour coverage of all Texas employers, it certainly highlights general attitudes towards the introduction of a 24-hour pilot project in Texas.

[14] Under the Texas workers' compensation system, employees have the statutory right to choose their own treating doctor; however, nonsubscribing employers do not fall under the jurisdiction of the Texas workers' compensation system. As a result, nonsubscribing employers may currently choose to require that injured employees select a doctor from the employer's list.

Doctor Monitoring Results for Work Hardening, Work Conditioning, and Chronic Pain Management Services

by D.C. Campbell and Amy Lee

This article is a continuation of the health care provider monitoring initiatives first described in the August 2002 Special Edition of the *Texas Monitor*.[1] That report discussed findings from a physical medicine study based on methodology developed by staff from the Research and Oversight Council on Workers' Compensation (ROC) and the Texas Workers' Compensation Commission (TWCC) to monitor the amount and duration of medical care provided to injured workers in Texas by individual health care providers.

The ROC's report in the 2002 Special Edition of the *Texas Monitor* presented the average utilization of specific physical medicine services for all health care providers in Texas, and profiled the practice patterns for sample health care providers whose practices showed significant disparities from those of their peers in the treatment of low back soft tissue and nerve compression injuries (two of the most costly and most common diagnoses in the Texas).

This article examines the utilization and duration of Work Hardening (WH), Work Conditioning (WC), and Chronic Pain Management (CP) services, and profiles the practice patterns of health care providers whose practices appear to be significantly different than the general population of health care providers who provide those services.

Methodology

The data used for this analysis came from TWCC's Medforms database, and covers the first 24 months of medical services received by workers who suffered low back soft tissue or low back nerve compression injuries in calendar year 2000.

ROC staff used univariate statistics to:

- determine the median (50th percentile) utilization of WH,WC, and CP services per injured worker for all health care providers in Texas;
- determine the median service utilization per injured worker for each health care provider; and
- compare a ranking of each health care provider's median to the median of all health care providers in Texas.

In order to improve the statistical validity of the results, ROC staff limited the analysis to health care providers with five or more patients. For a complete description of the data and methodology used to produce these doctor monitoring results, see *Texas Monitor* Volume 7, Number 2 Special Edition (August 2002).[2]

Results

Table 7 compares the number of services a typical (i.e., median or 50th percentile) health care provider in Texas would provide per injured worker with low back soft tissue or low back nerve compression injuries to the number of services a high utilizing (95th percentile) provider would administer per injured worker with the same diagnoses. For example, looking at low back soft tissue injuries, a typical

health care provider renders on average 19 CP services per patient, while a provider at the 95th percentile provides on average 160 services per patient – almost eight times as much. Clearly, this degree of overutilization could have an impact on overall medical costs in the Texas workers' compensation system.

Figure 9 illustrates how the WH practice patterns of four high utilization health care providers compare to the median practices of all providers in the state. While the median number of WH services provided by all Texas health care providers per injured worker with a low back nerve compression injury was 63 units of service, some high utilization providers billed for as many as 199 units of service per injured worker. For low back soft tissue injuries, the median number of WH services provided by all Texas health care providers per injured worker was 50 units of service; however, as Figure 9 illustrates, some providers render significantly more units of service per worker. Similar disparities in utilization are also evident with WC and CP services (see Figure 10 and Figure 11).

The study also revealed significant disparities when duration of treatment (in number of days) is considered. Table 8 compares the number of days a typical (i.e., median or 50th percentile) health care provider in Texas treats an injured worker with low back soft tissue or low back nerve compression injuries to the number of days a high utilizing (95th percentile) provider treats an injured worker with the same diagnosis. Overall, high utilizing health care providers render significantly longer durations of WH, WC, and CP treatments than the median health care provider (50th percentile).

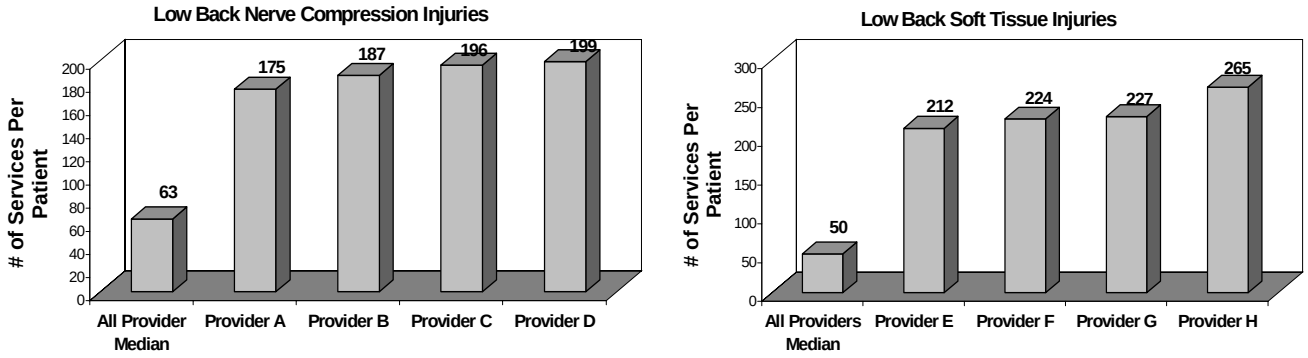
Figure 12 illustrates how the WH treatment durations of four high utilizing health care providers compare to the median WH treatment durations for all health care providers in the state. While the WH median treatment dura-

Table 7
Median Number of Work-Hardening, Work-Conditioning, and Chronic Pain Management Services per Patient
Injury Year 2000 – Two Years Post-Injury

Types of Physical Medicine	Low Back Soft Tissue Injuries		Low Back Nerve Compression Injuries	
	# of services per patient – all providers (50th Percentile)	# of services per patient – high utilizing providers (95th Percentile)	# of services per patient – all providers (50th Percentile)	# of services per patient – high utilizing providers (95th Percentile)
WORK HARDENING	50	195	63	204
WORK CONDITIONING	28	102	48	195
CHRONIC PAIN MANAGEMENT	19	160	26	143

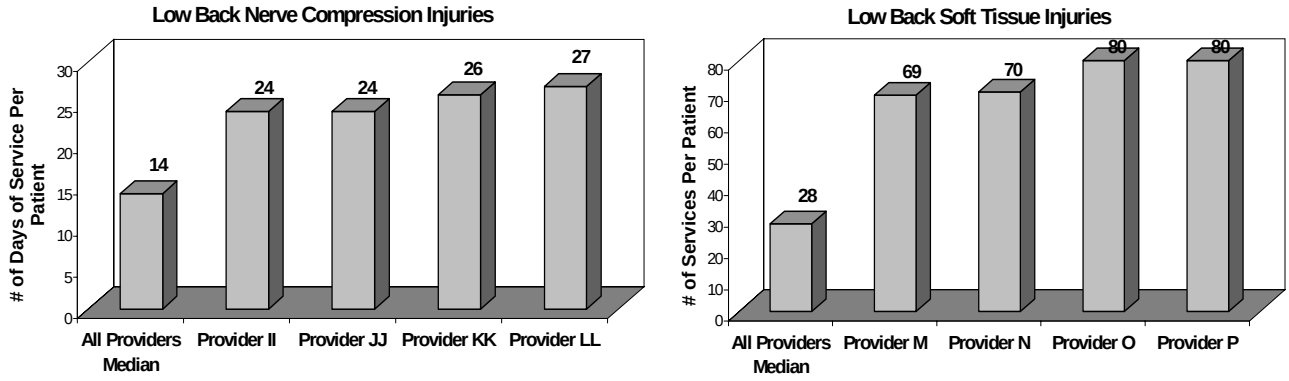
Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 9
Comparison of the Median Number of Work Hardening Services Per Patient for Selected Health Care Providers Compared with the Results for All Providers
Injury Year 2000 – Two-Years Post-Injury



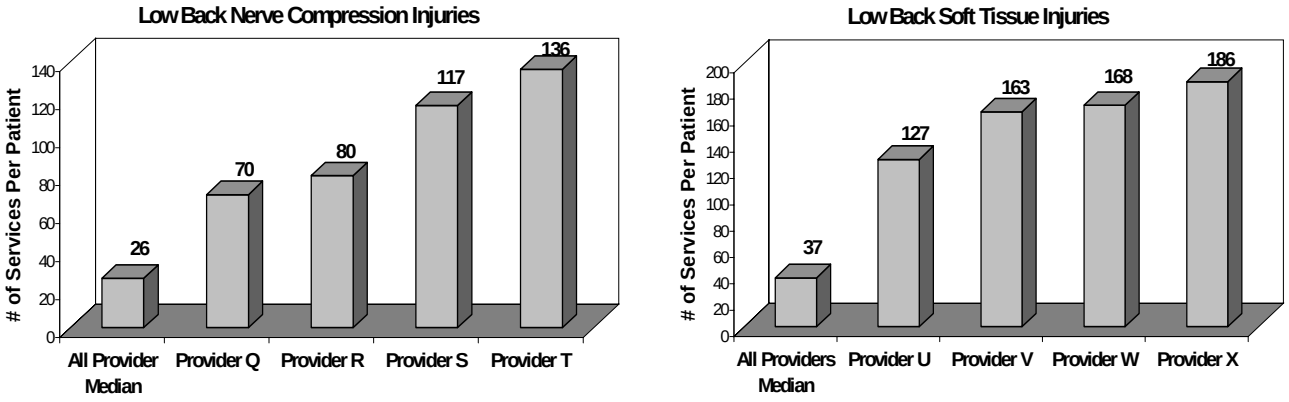
Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 10
Comparison of the Median Number of Work Conditioning Services Per Patient for Selected Health Care Providers Compared with the Results for All Providers
Injury Year 2000 – Two-Years Post-Injury



Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 11
Comparison of the Median Number of Chronic Pain Management Services Per Patient for Selected Health Care Providers Compared with the Results for All Providers
Injury Year 2000 – Two-Years Post-Injury



Source: Research and Oversight Council on Workers' Compensation, 2003.

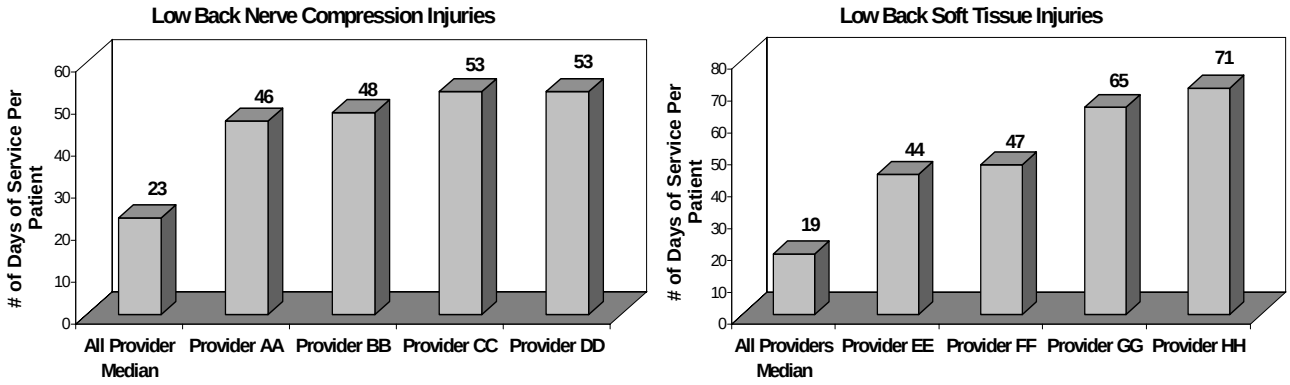
tion per injured worker with a low back soft tissue injury was 19 days for all Texas health care providers, some health care providers treated injured workers for as long as 71 days, or more than three times the duration for the median health care provider. Similar disparities are also evident with WC and CP services (Figure 13and Figure 14).

Table 8
Median Work Hardening, Work Conditioning, and Chronic Pain Management Treatment Durations
(number of days between first and last treatment)
Injury Year 2000 – Two Years Post-Injury

Types of Physical Medicine	Low Back Soft Tissue Injuries		Low Back Nerve Compression Injuries	
	# of days per patient – All providers (50th Percentile)	# of days per patient – high utilizing providers (95th Percentile)	# of days per patient – all providers (50th Percentile)	# of days per patient – high utilizing providers (95th Percentile)
WORK HARDENING	19	54	23	56
WORK CONDITIONING	15	41	14	47
CHRONIC PAIN MANAGEMENT	8	66	10	68

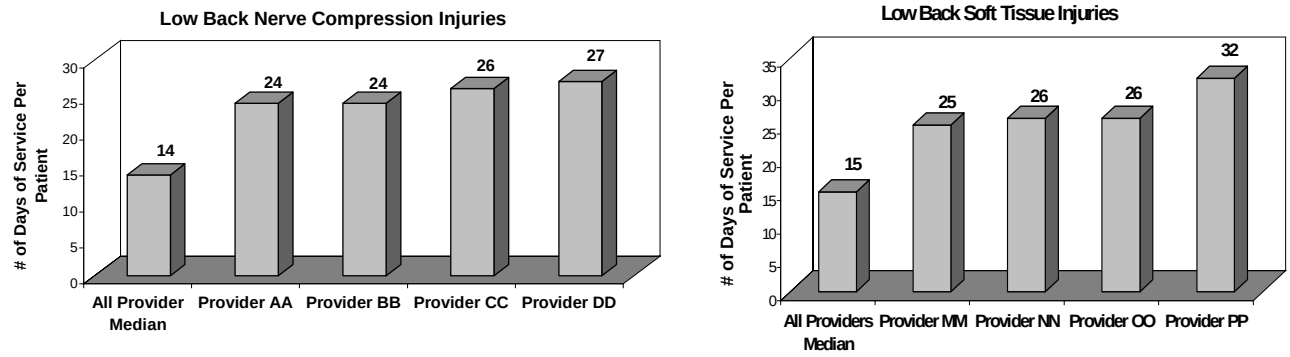
Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 12
Comparison of the Median Duration (in days) of Work Hardening Per Patient for Selected Health Care Providers Compared with the Results for All Providers
Injury Year 2000 – Two Years Post-Injury



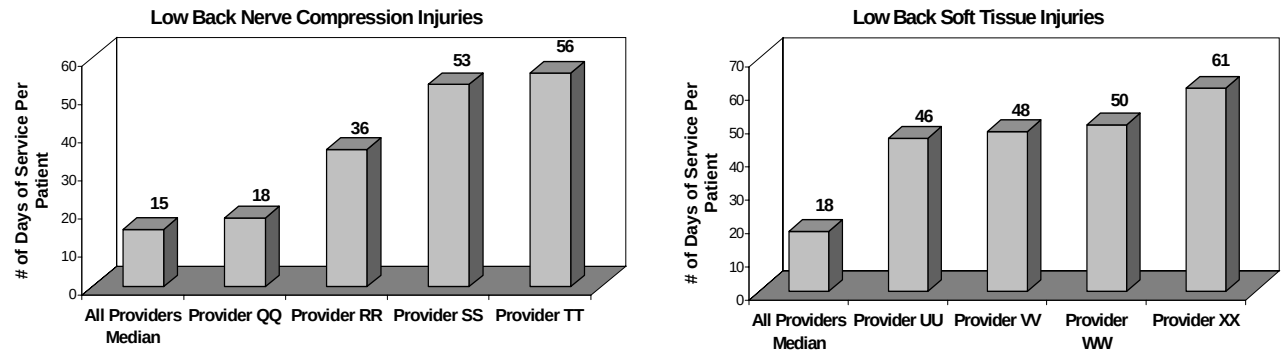
Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 13
Comparison of the Median Duration (in days) of Work Conditioning Per Patient for Selected Health Care Providers Compared with the Results for All Providers
Injury Year 2000 – Two Years Post-Injury



Source: Research and Oversight Council on Workers' Compensation, 2003.

Figure 14
Comparison of the Median Duration (in days) of Chronic Pain Management Per Patient for Selected Health Care Providers Compared with the Results for All Providers
Injury Year 2000 – Two Years Post-Injury



Source: Research and Oversight Council on Workers' Compensation, 2003.

Conclusion

The findings in this study on work hardening, work conditioning, and chronic pain management parallel the previous physical medicine findings published by the ROC. It appears that significant differences can be identified in the median practice patterns of all Texas health care providers and the practice patterns of health care providers at the 95th percentile. These disparities, while possibly indicative of excessive utilization and treatment durations, provide valuable information about where monitoring activities can best be directed to affect system improvements.

This monitoring tool may be effective in reducing medical costs and improving quality of medical care for injured workers in Texas in several ways. First, since TWCC now has greater authority to monitor and sanction health care providers with practices deemed excessive (per HB 2600, 77th Texas Legislature, 2001), this methodology can be an effective tool in identifying providers who warrant closer scrutiny from TWCC's Medical Advisor and the Medical Quality Review Panel (MQRP).

By the same token, this health care provider monitoring tool can also be effective in identifying providers who may warrant reduced utilization review or preauthorization requirements per Section 408.0231 (a) (4) of the *Texas Labor Code*.

Lastly, as results from the monitoring program are made public, system participants can begin to self-regulate their practice patterns to avoid sanctions and reap potential regulatory benefits. Lower medical costs could be realized as over-utilizing health care providers begin to adjust their practice patterns toward the Texas median.

Notes to pages 24-28

[1] See Research and Oversight Council on Workers' Compensation, "Health Care Provider Monitoring Results for Physical Medicine Services", *Texas Monitor* Vol. 7, No. 2 Special Edition (August 2002).

[2] To correct for missing or invalid modifiers, if a bill had the accurate CPT code and the payment received by the health care provider was a multiple of the payment recommended in TWCC's 1996 *Medical Fee Guideline*, it was designated as a WH or WC service. To correct for reported unit inaccuracies, ROC staff recalculated the unit field by dividing total payments per day of service by the appropriate per unit reimbursement in TWCC's 1996 *Medical Fee Guideline*. While TWCC's 1996 *Medical Fee Guideline* does not specify a reimbursement value for CP services, earlier analyses conducted by TWCC and ROC had concluded that the median payment per unit of CP was approximately $100. After the process of reassigning bills, recalculating units, and eliminating bills that were likely to increase errors, ROC staff identified for the study approximately 136,000 WH services, 33,000 WC services, and 32,000 CP services received by injured workers in the first 24 months following injuries sustained in 2000.

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